Peptic Ulcer Disease Clinical Discussion

Case history
A 40-year-old man presents to his primary care physician with a 2-month history of intermittent upper abdominal pain (epigastric discomfort). He describes the pain as a dull, gnawing ache. The pain sometimes wakes him at night, is relieved by food (eating) and drinking milk, and is helped partially by ranitidine. He had a similar but milder episode about 5 years ago, which was treated with omeprazole.

Physical examination reveals a fit, apparently healthy man in no distress. The only abnormal finding is mild epigastric tenderness on palpation of the abdomen.

Signs & Symptoms
Epigastric pain, usually 1 to 3 hours postprandial especially at bed time, and could be relieved by food ingestion.
The patient sometimes complained of Nausea, Oral flatulence, bloating, distension and intolerance of fatty food and Heartburn
Symptoms are relieved by antacids (very nonspecific).

Investigations
Testing for H. pylori.
Test using a carbon-13 urea breath test or a stool antigen test, or laboratory-based serology where its performance has been locally validated. If re-testing is required, a carbon-13 urea breath test is the chosen test. There is currently insufficient evidence to recommend the stool antigen test as a test of eradication.

Management
- Modification of behavior
- If drugs are the cause, then they should be stopped or replaced but this may not be possible.
- Cessation of smoking should be advised if applicable.
  (Smoking increases the risk of peptic ulcer and delays healing as well as opposing the action of H2-receptor antagonists. It has many effects on other parts of the gut including facilitating gastro-oesophageal reflux).

Treatment for H. pylori-associated ulcer disease is mainly directed at eradication of infection.

Healing ulcers - H. pylori-negative, NSAID induced (non-steroidal anti-inflammatory drugs such as Aspirin and Naproxen)-:
The NSAID should be stopped. More than 90% of gastric or duodenal ulcers heal with eight weeks of standard-dose H2-receptor antagonists – eg: ranitidine 150 mg twice a day if the NSAID is discontinued.

A large randomized trial has not shown any difference in gastric ulcer healing between groups receiving Esomeprazole 40 mg, خحق20 mg and ranitidine.

PPIs (Proton Pump Inhibitor) are better than standard-dose H2-receptor antagonists and Misoprostol for prevention of duodenal ulcers.
If patients are unable to tolerate PPI treatment, a systematic review of randomized trials found that double-dose H2-receptor antagonists reduce risk of both gastric and duodenal ulcers.

**Bleeding ulcers**
Early endoscopic intervention with ablative or mechanical treatment to the bleeding vessels is the treatment of choice.

**Management of recurrence and its prevention**
For gastric ulcer with H. pylori infection, Eradication therapy followed by proof of eradication and repeat endoscopy. If eradication is successful but the ulcer unhealed then malignancy needs to be considered.
Serology tests are applicable only for initial diagnosis, as they remain positive for a long period. For patients who have relapses, intermittent therapy and annual review are recommended.

**Monitoring**
Patients should be reviewed at the end of a course of treatment, especially H. pylori eradication, to confirm a satisfactory outcome.